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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45 er 12/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445474	A. BUILDING _____ B. WING _____	11/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE HEALTH CENTER	1633 HILLVIEW DRIVE ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to notify three residents (#3, #10, #55), of fifteen residents interviewed, of a roommate change prior to the arrival of the roommate. The findings included: Resident #3 was admitted to the facility on July 12, 2011, with diagnoses including Hypertension, Gait Abnormality, Muscle Weakness, and Osteoporosis. Medical record review of the Minimum Data Set (MDS) dated October 11, 2011, revealed the resident was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 11, with 15 being the highest possible score. Interview with the resident in the resident's room on November 1, 2011, at 8:39 a.m., confirmed the resident had not been notified prior to the arrival of a new roommate. Resident #10 was admitted to the facility on August 22, 2011, with diagnoses including Hemiplegia, Difficulty Walking, Diabetes Mellitus, Late Effect Cerebrovascular Disorder, and Muscle Weakness.	F 247	1. The Social Service Director met with resident #3 on 11/9/11 to notify her of her right to be notified before room/room mate change. The Social Service Director met with resident # 10 on 11/9/11 to notify her of her right to be notified before room/room mate change. The Social Service Director met with resident #55 on 11/9/11 to notify her of her right to be notified before room/room mate change. 2. An audit of new admissions for the last 30 days was conducted by the Social Service Director. The Social Service Director notified all four (4) residents room mates and/or responsible parties of their right to be notified before a room or room mate change on 11/9/11. 3. The Social Services Director was inserviced on 11/8/11 by the Administrator regarding the resident right to receive notice before room/roommate change. 4. The Director of Nursing will review documentation of room mates of new admits and residents with room changes weekly for 4 weeks, then monthly for 2 months and/or until 100% in compliance. All results will be reported by the Director of Nursing to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee is comprised of the Medical Director, Administrator, Director of Nursing,	11/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jeannie Barker, Administrator — 11/14/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 247	Continued From page 1 Medical record review of the MDS dated October 17, 2011, revealed the resident was cognitively intact, with a BIMS score of 15, with 15 being the highest possible score. Interview with the resident in the resident's room on October 31, 2011, at 11:46 a.m., confirmed the resident had not been notified prior to the arrival of a new roommate. Resident #55 was admitted to the facility on March 10, 2010, with diagnoses including Diabetes Mellitus, Hypertension, Muscle Weakness and Osteoporosis. Medical record review of the MDS dated August 8, 2011, revealed the resident was cognitively intact, with a BIMS score of 12, with 15 being the highest possible score. Interview with the resident in the resident's room on October 31, 2011, at 12:34 p.m., confirmed the resident had not been notified prior to the arrival of a new roommate. Review of the facility document on Resident Rights, section B, # 11, revealed "...The Center must promptly notify the resident and, if known, the Resident's legal representative or interested family member when there is: a. A change in room or roommate..." Interview with the Director of Social Service, in the Social Service office, on November 3, 2011, at 4:50 p.m., confirmed there was no documentation in the medical record verifying the residents had been notified of a roommate	F 247	Assistant Director of Nursing, Resident Assessment Nurses, Social Services, Activities, Dietary Manager, Environmental Supervisor and Rehab Manager.	

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F 247	Continued From page 2 change.	F 247		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to develop a comprehensive care plan for one (#10) of three reviewed for Rehabilitation; for one (#67) of one reviewed for Pressure Ulcer; and one (#95) of four residents reviewed for Pain Recognition and Management, of thirty-three residents reviewed. The findings included:	F 279	1. The Resident Assessment Nurse updated the comprehensive care plan and therapy assessed resident #10 on 11/4/11 to reflect the services being provided by the therapy department. The Resident Assessment Nurse updated the comprehensive care plan and the Treatment Nurse assessed resident #67 on 11/4/11 to reflect resident's current condition. The Resident Assessment Nurse updated the interim care plan on 11/4/11 for resident #95 to address pain management. Pain assessment completed by the Resident Assessment Nurse and Physician notified on 11/2/11. 2. The Director of Nursing, Assistant Director of Nursing and Resident Assessment Nurses completed review of care plans on 11/11/11 of all active residents to ensure that the care plan reflects correct and updated resident care information. The Director of Nursing added information to the CNA electronic care plan by 11/11/11. 3. The Resident Assessment Nurses and Rehab Manager were inserviced on 11/7/11 by the Director of Nursing regarding the comprehensive care plan for each resident to include measurable objectives and timetables to meet resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment and	11/15/11

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F 279	Continued From page 3 Resident #10 was admitted to the facility on August 22, 2011, with diagnoses including Late Effects Cerebrovascular Accident and Dysphagia. Observation of the resident's room on November 2, 2011, at 10:10 a.m., revealed the resident in the recliner. Continued observation revealed an elbow splint and a wrist splint on the bedside table. Continued observation revealed the resident had a contracture of the left arm and wrist. Observation on November 3, 2011, at 7:48 a.m., revealed the resident was in a wheelchair in the dining room for the breakfast meal. Continued observation revealed the resident was observing while the Certified Nursing Assistant (CNA #2) buttered the toast; opened the milk carton; added sugar to the oatmeal; and removed the lid from the thickened juice container. Interview in the hall with CNA #1 (assigned to care for resident #10) on November 3, 2011, at 1:45 p.m., revealed, resident #10 "Needs extensive assist to get dressed...we have to set up (resident's) tray and remove the lids from the drinks...cannot do it without help...Don't know anything about the splints in the room..." Continued interview revealed the CNA was unaware the resident was able to perform activities using both hands. Review of the care plan dated August 22, 2011, revealed an identified 'Problem/Need' of Rehabilitation and the intervention of Speech Therapy (ST), Occupational Therapy (OT), and	F 279	updating the care plan and the electronic CNA care plan to reflect the current needs of the resident. 4. The Care Plan Team will review all completed care plans and electronic CNA care plan weekly to ensure care plan reflects correct and current resident care information. 100% of completed care plans will be reviewed weekly for 4 weeks, 15 care plans will be reviewed for 2 months and/or until 100% in compliance. The Care Plan Team is comprised of the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Social Services and Activities Director. All results will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement Committee comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Resident Assessment Nurses, Social Services, Activities Director, Dietary Manager, Environmental Supervisor and Rehab Manager.	

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F 279	Continued From page 4 Physical Therapy (PT) to evaluate and treat. Continued review revealed no measurable goals, no interventions, and no revision since admission (August 22, 2011). Review of the OT notes for September and October, 2011, revealed the resident was "completing 2-handed activities" and encouraged by therapy staff to use the contracted hand. Interview with the Certified Occupational Therapy Assistant (COTA #1) in the dining room on November 3, 2011, at 1:52 p.m., revealed the resident "has made a lot of progress...needs encouragement...wants to become more independent to be able to go home." Continued interview revealed the splints (in the resident's room) came with the resident from home. Interview with COTA #1 revealed "it certainly would not hurt at all for the splints to be worn at night...have not talked to nursing about the splints." Interview with the Director of the Therapy Department on November 3, 2011, at 4:10 p.m., revealed resident #10 remains in OT and PT and is continuing to meet short-term goals. Interview with the Director revealed, "When we (therapy department) refer residents to the Restorative nursing department we will talk with them (nursing) regarding the resident's functional ability". Review of the facility policy (un-numbered) titled Care Plans-Comprehensive, revealed, "Each resident's comprehensive care plan has been designed to build on the resident's strength; reflect treatment goals and objectives in	F 279		

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F 279	Continued From page 5 measurable goals...5. Care plans are revised as changes in the resident's condition dictates." Interview with the Resident Assessment Nurse on November 3, 2011, at 11:03 a.m., revealed the nursing department and the therapy department usually talk every day and "Try to work together to establish interventions to help the resident achieve their goals." Continued interview verified the staff should encourage the resident to do as much as possible to strive to achieve independence as evaluated by the therapy department. Continued interview confirmed the facility failed to develop a care plan to include therapy. Resident #67 was re-admitted to the facility on October 6, 2011, with diagnoses including Advanced Alzheimer's Dementia, Deconditioning, Dysphagia (difficulty swallowing), Aspiration Pneumonia, and Pressure Ulcer. Medical record review of the physician's re-admission orders dated October 6, 2011, revealed the resident was receiving hospice care and a pureed diet. Medical record review of the Departmental Notes dated October 7, 2011, revealed "...noted stage two to sacrum, new treatment orders received and noted,.." Medical record review of the Wound Care Flow Sheet dated October 7, 2011, revealed "...T/R (turn and reposition) Q 1 hour and PRN (as	F 279		

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F 279	Continued From page 6 needed) ^ (up) for meals..." Medical record review of the Wound Care Flow Sheet dated October 13, 2011, revealed "...T/R Q1-2 hours & PRN, pillows used for comfort & support...Bilateral (both) hands with 1+ edema noted & LE's (lower extremities) bilaterally with 1+ edema- Bilateral lower legs are firm to touch...BLE's elevated, moisturizing lotion applied to BLE's..." Medical record review of the Wound Care Flow Sheet dated October 20, 2011, revealed the pressure ulcer had declined to a stage 3. "...LAL (low air loss) mattress in use..." Medical record review of the Minimum Data Set dated October 13, 2011, revealed the resident required extensive assistance with bed mobility; transfers; and eating, was non-ambulatory, and was no longer receiving physical (PT) or occupational (OT) therapy. Medical record review of the resident's current care plan revised on November 2, 2011, revealed "...resident to be treated by PT/OT, Extensive asst. provided with ambulation...At risk for impaired skin integrity and risk for further skin impairment...Diet: NAS Mechanical Soft ..." Further review revealed no problem for the stage 3 pressure ulcer; approaches for the resident's decline and was non-ambulatory; no longer being treated by PT or OT; the resident's diet change; the resident required extensive assistance with bed mobility, transfers, and eating; the resident required to be turned and repositioned every 1-2 hours and PRN.	F 279		

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F 279	Continued From page 7 Interview on November 3, 2011, at 7:30 p.m., in the conference room with the Director of Nursing confirmed the resident's care plan was not revised to include the resident's decline including the stage 3 pressure ulcer. Resident #95 was readmitted to the facility on October 15, 2011, and discharged to the hospital on October 16, 2011, with complaints of chest and abdominal pain. Medical record review revealed the resident was readmitted on October 20, 2011, with diagnoses including Surgical Repair of Abdominal Aortic Aneurysm, Atherosclerotic Vascular Disease, Hypertension, Chronic Obstructive Pulmonary Disease, and Depression. Review of the Minimum Data Set (MDS) dated October 27, 2011, revealed the resident scored 13 of 15 on the Brief Interview for Mental Status indicating the resident's cognitive abilities were intact. Review of the initial skin assessment dated October 15, 2011, revealed the resident had 36 abdominal staples, midline from the thoracic area to the pubis area, and 14 staples in the left and right groin areas. Observation in the resident's room on November 1, 2011, at 8:01 a.m., revealed the resident exhibited several episodic jerking movements accompanied with facial grimacing during the resident interview. Review of the resident's Interim Care Plan dated October 15, 2011, revealed no documentation pain management had been addressed on the resident's care plan.	F 279		

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F 279	Continued From page 8 Interview with the Director of Nursing in the MDS office on November 3, 2011, at 3:35 p.m., confirmed the interim care plan had not been revised to address pain management.	F 279		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	1. The Director of Nursing removed the 50 ml(milliliter) bottle of Lidocaine immediately and placed in pharmacy destruction box on 11/2/11. 2. Medical Records Nurse completed 100% audit on both (2) medication carts on 11/2/11 and revealed no other expired medications on carts. 3. All licensed nurses, RN/LPNs, were inserviced on 11/2/11 by the Director of Nursing and Assistant Director of Nursing regarding manufacturers recommendations for discarding expired medications. 4. The Director of Nursing and/or Assistant Director of Nursing will audit both (2) medication carts weekly for 4 weeks, then monthly for 2 months and/or until 100% in compliance to ensure all expired medications are discarded timely. All results from the audit will be reported by the Director of Nursing monthly to the Quality Assurance Committee. The Quality Assurance Performance Improvement Committee is comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Resident Assessment Nurses, Social Services, Activities Director, Dietary Manager, Environmental Supervisor and Rehab Manager.	11/15/11

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F 431	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, manufacturers recommendations, and interview, the facility failed to dispose of expired medications on one medication cart (200 hall) of two medication carts observed. The findings included: Observation with Licensed Practical Nurse (LPN) #1 on November 2, 2011, at 10:44 a.m., of the medications stored on the 200 hall medication cart revealed a 50 ml (milliliter) bottle of Lidocaine, three-fourths full, opened, and dated September 28, 2011. Interview with the Director of Nursing in the conference room on November 2, 2011, at 1:38 p.m., confirmed, after reviewing the manufacturers recommendations, the Lidocaine should have been discarded twenty-eight days after the bottle was opened.	F 431		